TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #12-375(E)

DIGEST

Temporarily amends 405 IAC 1-8-3 to modify Medicaid reimbursement policy associated with specified other provider-preventable conditions. Temporarily amends 405 IAC 1-10.5-5 to modify Medicaid reimbursement policy associated with specified health care-acquired conditions and other provider-preventable conditions. Temporarily amends 405 IAC 1-11.5-2 to modify Medicaid reimbursement policy associated with specified other provider-preventable conditions. Authority: IC 4-22-2-37.1(a)(19); IC 12-15-21-2; IC 12-15-21-3. Effective July 1, 2012.

SECTION 1. **(a) This SECTION is supplemental to 405 IAC 1-8-3.**

(b) The state identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for nonpayment:
(1) wrong surgical or other invasive procedure performed on a patient;
(2) surgical or other invasive procedure performed on the wrong body part; and
(3) surgical or other invasive procedure performed on the wrong patient.

SECTION 2. **(a) This SECTION supersedes 405 IAC 1-10.5-5.**

(b) This section applies to the following:
(1) Payment for inpatient stays reimbursed according to the DRG and level-of-care methodologies.
(2) All inpatient hospital facility reimbursement provisions, including the following:
(A) Medicaid supplemental payments.
(B) Medicaid enhanced payments.
(C) Medicaid disproportionate share hospital payments.

(c) The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a health care-acquired condition that was not present on the date of admission. If a health care-acquired condition is not present on the date of admission, the discharge will be assigned to a DRG as though the health care-acquired condition was not present.

(d) Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

(e) For purposes of this section, a "health care-acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and 42 CFR 447.26(b) and in effect on the date of admission.

(f) The state identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for nonpayment:
(1) wrong surgical or other invasive procedure performed on a patient;
(2) surgical or other invasive procedure performed on the wrong body part; and
(3) surgical or other invasive procedure performed on the wrong patient.

SECTION 3. **(a) This SECTION is supplemental to 405 IAC 1-11.5-2.**

(b) The state identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for nonpayment:
(1) wrong surgical or other invasive procedure performed on a patient;
(2) surgical or other invasive procedure performed on the wrong body part; and
(3) surgical or other invasive procedure performed on the wrong patient.

SECTION 4. SECTIONS 1 through 3 of this document take effect on July 1, 2012.

SECTION 5. SECTIONS 1 through 3 of this document expire on June 30, 2013.

LSA Document #12-375(E)
Filed with Publisher: June 15, 2012, 2:25 p.m.

Posted: 06/27/2012 by Legislative Services Agency
An html version of this document.